method, with its emphasis on disinterested investigation, careful analysis of data, conservative scepticism and consensual agreement, is the best method human beings have for approaching the truth.[2]

Hoey is incredibly naïve to think that there must be merit in alternative therapies because those with "a higher level of education" use them. Education (it is sad to admit) does not guarantee the ability to think critically and to use an informed scepticism in considering claims for the effectiveness of treatments.

It is misleading to refer to scientific medicine as "the establishment." This term connotes some rigid ideological position whereas the scientific method has revealed, not just in medicine, a continually changing reality through revisions and self-correction.

If patients are "taking control of the agenda" regarding their treatment, let them do so. But let us not dignify treatment that is completely unsupported by scientific evidence with a medical endorsement. The best physicians can do is to inform patients of the lack of valid evidence supporting claims for alternative treatments (with a few exceptions) and to try to instill in patients an enlightened scepticism. I recommend to many patients *The Wellness Letter* published by the University of California at Berkeley. Contrast the sceptical (not negative) attitude toward alternative treatments in this publication intended for the lay public with the *CMAJ* articles criticized by Ian Tannock and David Warr.[3]

This editorial would have been bad enough coming from any physician. Coming from the Editor of *CMAJ* it makes me sad and embarrassed to be a member of the Canadian Medical Association.

Paul C.S. Hoaken
Psychiatrist
Bath, Ont.

References

1. Hoey J. The arrogance of science and the pitfalls of hope [editorial]. *CMAJ* 1998;159(7):803-4.
2. Strahler AN. *Understanding science*. Buffalo (NY): Prometheus Books; 1992.
3. Tannock IF, Warr DG. Unconventional therapies for cancer: A refuge from the rules of evidence? *CMAJ* 1998;159(7):801-2.

[Editor's note:]

Owing to an editorial oversight, this letter was not published in 1999 as scheduled.

Overnight dialysis

In June 1968, a colleague and I reported the case of a 14-year-old malnourished girl with end-stage renal disease who was dialysed daily, except Sunday, for 8–14 hours overnight.[1] She had an excellent response, went home on this regime and eventually received a transplant. In October of the same year, we described our experience with 22 patients on home hemodialysis, 20 of whom were dialyzed 10 hours overnight 3 times weekly with the patient asleep for most of the procedure.[2] This regime was initiated by groups at the Royal Free Hospital in England[3] and in Seattle.[4]

My question to Andreas Pierratos, the author of "Nocturnal hemodialysis: dialysis for the new millennium,"[5] is this. To which millennium was he referring?

Michael Kaye
Nephrologist
Hudson, Que.

References

1. Kaye M, Comty C. Nutritional repletion during dialysis. *Am J Clin Nutr* 1968;21:583-9.
2. Kaye M, McDade D, Dufresne L, Comty C. Hemodialysis at home. *CMAJ* 1968;99(16):779-85.
3. Baillod RA, et al. *Proc Eur Dial Transplant Assoc* 1965;2:99.
4. Curtis FK, Cole JJ, Tyler LL, Scribner BH. Hemodialysis in the home. *Trans Am Soc Artif Intern Organs* 1965;11:7-10.
5. Pierratos A. Nocturnal hemodialysis: dialysis for the new millennium. *CMAJ* 1999;161(9):1137.

[The author responds:]

I agree that the Tassin regimen of long dialysis 3 times a week is well known and inspirational. I believe that the systematic study and programmed application of the long and frequent dialysis regimen (nocturnal hemodialysis) will make it the preferred dialysis modality for a large number of patients. By the end of this year, 60 to 80 patients will be receiving nocturnal hemodialysis in Ontario, and a faster growth is anticipated in the future. This indeed makes it the most exciting dialysis modality in the new millennium.

Andreas Pierratos
Nephrologist
Humber River Regional Hospital
Toronto, Ont.

The journey through the ICU

As a neurosurgeon who deals with critically ill patients every day, I read a recent article by Deborah Cook and colleagues with interest.[1] Upon reflecting, I felt that understanding of the reasons why advanced life support is withheld, provided, continued or withdrawn in the ICU could be enhanced by using an alternative metaphor: that of the ICU stay and its attendant use of technology as a journey.

At times the journey is complete by the time the patient arrives in the ICU. At other times, however, the journey through the ICU becomes a trip through uncharted waters, and in these cases the ship has no power against the ravages of nature.

In this context, medical technology may be viewed as one means of taking the journey. The withdrawal of support may be viewed as halting one means of transportation, while its continuation may be considered a decision to carry the traveller — the patient — forward. When technology is withheld, it may be considered a means of travel that the traveller cannot or chooses not to use.

Other modes of transportation are possible for journeys. This might be the reason why some patients have positive outcomes in the course of their illness that cannot be explained by contemporary western medicine.

On the journey through the ICU, there are many travellers. They are all affected by the trip, whether they consciously realize it or not. In a journey,